York, Brian D (DOH)

From: Hart-Anderson, Cammy <Cammy.Hart-Anderson@co.snohomish.wa.us>
Sent: Thursday, February 22, 2018 9:30 AM
To: DOH HSQA Complaint Intake
Subject: FW: Smokey Point Behavioral Hospital
Attachments: 20180221135432749.pdf

Good Morning,

This email regarding Smokey Point Behavioral Hospital was forwarded to me in my role as Division Manager of Snohomish County's Division of Behavioral Health and Veteran Services. As you can see, members of the legislature have also received this email. It's my understanding that North Sound BHO is sharing this email with David Reed, DBHR as well.

The concerns stated in this email mirror the concerns my DMHPs have expressed as well as the concerns of our ITA court team that travels to psych hospitals to conduct court proceedings in our county. I'm attaching a letter that outlines safety concerns related to Smokey Point Behavioral Hospital as well as issues at Fairfax that went to DBHR this week.

Please feel free to contact me if I can be of any help. Our concern truly is the safety of the patients, our staff and the staff of Smokey Point Behavioral Hospital.

Thank you - Cammy

Cammy Hart-Anderson, Division Manager
Division of Behavioral Health and Veteran Services
Snohomish County Human Services
Cammy.Hart-Anderson@snoco.org
425.388.7233

From: *1 - Name - Whistleblower Regarding Health Care Provider or Health Care Facility - RCW 43.70.07...*
Sent: Tuesday, February 20, 2018 6:36 PM
To: annette.cleveland@leg.wa.gov <annette.cleveland@leg.wa.gov> <annette.cleveland@leg.wa.gov>; steve.conway@leg.wa.gov; karen.keiser@leg.wa.gov; Patty.Kuderer@leg.wa.gov; mark.mullet@leg.wa.gov; barbbailey10@gmail.com; rbecker44106@gmail.com; Kevin.VanDeWege@leg.wa.gov; annrivers18@comcast.net; Joe.Fain@leg.wa.gov; michelle.caldier@leg.wa.gov; Negheen.Kamkar@leg.wa.gov; Kendra.Coburn@leg.wa.gov; richard.debolt@leg.wa.gov; paul.graves@leg.wa.gov; paul.harris@leg.wa.gov; Ann.Dasch@leg.wa.gov; drew.macewen@leg.wa.gov; Curtis.Knapp@leg.wa.gov; jacquelin.maycumber@leg.wa.gov; Maureen.Haeger@leg.wa.gov; jay.rodne@leg.wa.gov; joe.schmick@leg.wa.gov; Taemin.Um@leg.wa.gov; Sarah.Kohout@leg.wa.gov <Sarah.Kohout@leg.wa.gov> <Sarah.Kohout@leg.wa.gov>; Leanne.Horn@leg.wa.gov
Cc: Jon Nehring <jnehring@marysvillewa.gov>; info@arlingtonwa.gov <info@arlingtonwa.gov>
Subject: Smokey Point Behavioral Hospital

Honorable Senators, State Representatives, and Mayors,

I am writing you concerning our new Mental Health Hospital, Smokey Point Behavioral Hospital. Currently in our State there is a great need for mental health care, and the opening of a new hospital was a milestone for our region. However, as a former member of the hospital, and speaking on behalf of nearly the entire staff who fear the loss of their jobs if they speak out, this facility is extremely detrimental to the health of the patients and the staff. With the hospital being woefully understaffed and mismanaged, patient treatment has been almost entirely ignored.

When the Chief Nursing Officer, CEO, and parent company, US Health Vest have been notified, staff has been told to ignore state and federal laws.

Some of the issues are: not having basic supplies for patients, such as toothbrushes, toothpaste, socks, underwear, deodorant, soap and shampoo. The facility itself it very dirty and unhygienic, with patients and staff constantly complaining the hospitals management about the conditions there. There have been numerous suicide attempts as well as frequent self harming of patients that have been ignored, numerous physical fights between patients, who are then made roommates of left as roommates, numerous injuries to staff due to understaffing, not being able to take any breaks or lunch breaks due to staffing, and inability to do ANY group sessions, which the patients and insurance companies are being paid for, due to only having a nurse and mental health technician to care for a unit of 15 to 28 patients, many who meet a staffing criteria of 1:5, or 1:1.

Staff is under constant video surveillance, with any deficiencies on their part being swiftly and harshly dealt with, while in the same videos the patient care is being ignored, with the hospital management saying they have never seen it. An example is a doctor ordering staff to allow an adolescent patient to harm herself and to "just clean up the blood after she is done." When skin checks are being done on adolescents, corporate policy is for two staff of the same sex as the patient to be present, but due to staff shortages, adolescents from 12 years old to 18 years old are having to expose their privates to members of the opposite sex against their will.

Due to management trying to fill every bed, it is common place for patients to be stuck into any open bed, regardless of their diagnosis and age. For example, young patients being stuck on a geriatric unit, high acuity patients being stuck on a low acuity unit, or patients that are on a 5' restriction from each other being made roommates. High acuity patients, patients who have tried to commit suicide in the facility, or violent patients, all who require a 1:1 staffing ratio are being allowed to freely roam without escort, and the required constant supervision, 5 minute checks and 15 minute checks are being completely ignored due to staffing. There have even been cases of patients being stuck in a seclusion room because there were no open beds available! When self admitted patients ask to leave Against Medical Advice, the are frequently told "too bad, your not going anywhere", and numerous patients have told myself and other staff that the are worse when they leave than when they arrived. Despite a patients condition, it is common practice to see patients kicked out the second that their insurance runs out, even if they are suicidal or homicidal.

Lastly, with a new military unit being opened at Smokey Point Behavioral Hospital, I worry for the veterans, reservists, and active duty service members. They will not receive adequate care in this facility, and it would be a great injustice for them to be sent somewhere with such deplorable conditions.

I implore you to step in and correct the issues faced in this hospital so that the patients can receive the care that they so badly need, and rightly deserve.

Thank you for your time, and please contact me if you need any further information or have any question.
Very Respectfully,

1 - Name - Whistleblower Regarding Health Care Provider or Health Care Facility - RC...

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TO: David Reed [Acting Office Chief, Division of Behavioral Health and Recovery]

FROM: Cammy Hart-Anderson [Division Manager, Snohomish County Division of Behavioral Health and Veterans]
Joe Valentine [Executive Director, North Sound Behavioral Health Organization]

Subject: Fairfax Hospital and Smokey Point Behavioral Hospital Concerns

Dear Mr. Reed,

The North Sound BHO has become aware of a series of concerns related to Fairfax Hospital and now, Smokey Point Behavioral Hospital, that we feel need to be brought to the attention of the Division of Behavioral Health and Recovery. Although we have no oversight of these hospitals, many individuals from our region use them for both voluntary and involuntary inpatient care and treatment. The care for all patients using these facilities are the reason for this letter.

We would like to focus on three areas of concern: involuntary treatment, quality of care, and safety concerns. The concerns listed are detailed, many brought to our attention by Snohomish County.

Fairfax Hospital Concerns

Involuntary Treatment

Fairfax Hospital has two inpatient psychiatric units in Snohomish County, both of which take involuntary and voluntary patients. Snohomish County designated mental health professionals (DMHPs) function in the role of the court liaison in all facilities in Snohomish County. Though training began before either Fairfax facility opened (FFX-Everett opened October 2014 and FFX-Monroe opened January 2016), meetings, trainings, emails and phone calls have been ongoing in an attempt to reach a resolution. However, issues impacting involuntarily detained patients' civil rights continue on a regular basis.

The process to notify Snohomish County DMHP court liaisons is simple: call 425-388-7214 to notify that an involuntary patient has been admitted and fax the legal paperwork. Both the voicemail and the fax are operational 24/7. In spite of the simplicity of the notification process, involuntary patients are regularly admitted, with Fairfax staff failing to consistently notify Snohomish County DMHPs and thus, court hearings are not held within the mandated 72 hours in violation of 71.05.170. Psychiatrically unstable patients are being released to the community without being adequately treated. It is also important to note that many of the respondents being treated at Fairfax are from outside our region, from the counties of Spokane, Adams, Grant, and beyond.

Below is a snap-shot of some of the issues encountered, reported by the DMHP supervisor who monitors these cases:

- **2018**: Thus far, there have had six incidents. In all matters, Snohomish County DMHP court liaisons were not verbally notified or provided with legal paperwork for the respondents Fairfax admitted. As a result, in three of those matters, further involuntary commitment was not able to be pursued due to this lack of notification, and the lack of the necessary time for the involuntary treatment team to pursue further commitment. These cases were dismissed by the court secondary to this, though the respondents were still acutely mentally ill and in need of psychiatric treatment. In one case, Fairfax was not able to produce legal paperwork for the respondent they admitted, which is also a violation of the patient's rights. Snohomish County has consistently had cases where the timeframe when the person was initially detained versus the time when the DMHPs became aware of them being in our county, has been grossly violated.
- **2017**: Snohomish County had over 20 respondents in similar scenarios. For each respondent, no legal paperwork was provided to Snohomish County DMHP court liaisons. In three cases, Fairfax was not able to provide or produce legal paperwork, yet the respondents had all been involuntarily admitted. It is not uncommon for Fairfax to have no idea what type of hold the respondent that they admitted are on, nor do they have the appropriate legal paperwork. Snohomish County has had cases where Fairfax believed a client

was on a 14-day order from a different county; however, this has not been the reality which resulted in not being able to move forward with further commitment. In three cases (that the DMHP was aware of), the respondents were held past the 72-hour hold and without further legal paperwork, legal involvement, and did not convert to voluntary status. One patient was held without a legal status for over 3 weeks, and another for over one week.

- It is important to note that prior to 2017, Snohomish County court liaisons also encountered the same issues in their dealings with Fairfax Hospital. They have attempted on multiple occasions to remedy these situations without success. Cases have been dismissed by the court secondary to Fairfax's failure to provide notice to Snohomish County DMHP court liaison resulting in premature releases and psychiatrically unstable patients being discharged.

Documentation

Snohomish DMHP court liaisons have had consistent issues related to: documentation in the medical record of one patient that is actually for a different patient; failure to document situations/incidents (Court Liaisons have observed and witnessed altercations on the unit involving threats, yelling, hitting walls, etc., yet this information or "incident" has not been documented anywhere); documentation in the medical record is contradictory with what has been reported, and/or is contradictory between disciplines. Court liaisons rely on the medical record, as part of their investigation, to help formulate their opinion regarding further commitment, and later to use this information as part of their testimony in court. The clinical therapist notes are also quite lacking in both their content and when speaking to pursing less restrictives. They have had multiple cases where the clinical therapist has not documented at all on a respondent: both in terms of an assessment and less restrictive planning. The importance of adequate and accurate information and documentation is a key part in working on appropriate next steps.

Quality Concerns

North Sound has convened numerous meetings with Fairfax to attempt to address quality issues, related to clinical documentation, utilization management, intake procedures and discharge planning. They have and remain a significant outlier to other consistent inpatient practices, maintained by other regional hospitals. Our medical director, in particular, has addressed clinical documentation with the clinical director to attempt to create some consistency. The intake process has been and remains disjointed, creating some of the issues noted above. There appears to be gaps in the flow of communication between intake and the inpatient units, creating timeline issues as well as inconsistent voluntary practice for admissions.

Smokey Point Behavioral Hospital Concerns

Safety Concerns

Smokey Point Behavioral Hospital (SPBH) has been in operation in Snohomish County since June of 2017 with 116 psychiatric beds. SPBH has 70 E&T (ITA) certified beds, 55 beds for adults and 15 for adolescents. Currently there are 46 involuntary patients at SPBH.

Snohomish County DMHPs function in the role of the court liaison in all facilities in Snohomish County. In addition, their ITA court team travel from psych hospital to psych hospital for court hearings; therefore, in order to serve the respondents in the best possible way and to assure smooth proceedings, the court also has a vested interest in good working relationships. Snohomish County DMHP court liaisons and the ITA court team have been on-site at SPBH regularly since the facility opened in June 2017.

Since SPBH opened, there have been ongoing attempts to collaborate and problem-solve various issues. While issues related to intake procedures and notification have been resolved, serious safety concerns appear to be escalating. Snohomish County has been concerned for the safety of SPBH's patients, their DMHP court liaisons, the ITA court team and SPBH's staff. Snohomish County believes SPBH does not have sufficient, qualified, trained staff given the number of beds and the acuity of the patients.

Specific safety concerns:

- As a result of lack of SPBH staff presence and lack of staff availability when requested during evaluation, when serving detention papers or when a patient is agitated, Snohomish County staff do not feel safe being on the SPBH units.

- Patients have reported to Snohomish County and testified in court that they don't feel safe on the SPBH units.
- SPBH staff have stated to Snohomish County on several separate occasions that staffing is inadequate and that it is "only a matter of time" until someone will get hurt or worse. "It's not a question of if someone will die, but when" is a quote from a SPBH provider to one of Snohomish staff on 2-10-18.
- One patient who they were called in to evaluate could not be located by the DMHP. She was told no staff were available and to "go find him in his room". When she did she heard the shower running and informed staff. Upon her insistence, SPBH staff went to look for him and found him unresponsive/catatonic in the shower. Generally, individuals who are being referred to the DMHP are closely monitored as danger has been alleged.
- Another DMHP had to walk the hallways until she found a staff member that could accompany her to serve detention papers to an agitated, actively-threatening patient. On other inpatient units, staff are generally in line of sight.
- In another case, a patient stated to the DMHP "I am going to kill myself the minute you leave". Since this patient was being detained, the DMHP walked with the patient to the nurse's station in order to get SPBH staff, but the desk was unstaffed, and no one was in the vicinity. After some time, a tech walked by and the DMHP asked him to stand with the patient so she could go find a nurse to assure the patient's safety.
- On another incident, one of the DMHPs was evaluating a patient in a meeting room with all glass windows in line of sight of the nurse's station. The patient became very agitated, started yelling, gesturing and advancing toward the DMHP. Presumably the yelling could be heard and the DMHP generally assumes that psych hospital staff keep an eye out for this kind of incident and intervene quickly. In this case however, the Snohomish County staff had to go to great lengths to get the attention of staff who finally slowly approached and asked what the matter was, despite the obvious.
- Smokey Point staff do not ask who the Snohomish County staff are or if they need help when they walk in which is unusual and unsettling for a psychiatric inpatient unit.

General Comments Regarding Concerns

The issues noted above are just some of the concerns that have been brought to our attention. But they are specific and alarming. The oversight and review of these facilities rests with DBHR. The safety to our patients, DMHP staff, and the community require these programs function per the inpatient requirements addressed in WAC and RCW.

The North Sound BHO and the Snohomish County DMHP staff have met regularly with both Fairfax Hospital and Smokey Point Behavioral Hospital leadership and staff to attempt to resolve these issues. Fairfax Hospital and Smokey Point Behavioral Hospital staff appear to have made a good faith effort to work with us, but serious areas of concern remain unresolved and we feel we need to ask the appropriate state agency to follow up on our concerns.

The North Sound BHO is requesting that either DBHR and/or the appropriate state agency conduct a quality of care review at both hospitals and include a consideration of the issues and examples we have provided as a part of this review. We're willing to cooperate with this review in any way we can.

Sincerely,

Cammy Hart-Anderson
Division Manager
Snohomish County Division of Behavioral Health and Veterans

Joe Valentine
Executive Director
North Sound Behavioral Health Organization